Articles

Helping Pregnant Teenagers

DANIEL BLUESTEIN, MD, *Norfolk, Virginia, and*
M. ELIZABETH STARLING, MS, LPC, *Ashville, North Carolina*

Teenagers who are pregnant face many difficult issues, and counseling by physicians can be an important source of help. We suggest guidelines for this counseling, beginning with a review of the scope and consequences of adolescent pregnancy. Communication strategies should be aimed at building rapport with techniques such as maintaining confidentiality, avoiding judgmental stances, and gearing communication to cognitive maturity. Techniques for exploring family relationships are useful because these relationships are key influences on subsequent decisions and behaviors. We discuss topics related to abortion and childbearing, such as safety, facilitation of balanced decision making, the use of prenatal care, and the formulation of long-term plans. Physicians who can effectively discuss these topics can help pregnant teenagers make informed decisions and improve their prospects for the future.

(Bluestein D, Starling ME: Helping pregnant teenagers. West J Med 1994; 161:140-143)

Adolescent pregnancy is an endemic social concern with damaging health consequences. This harmful potential generates costs exceeding $20 billion a year.[1] Physicians can intervene as advocates of prevention of teenage pregnancy. The importance of another key intervention, counseling the already-pregnant teenager, is less widely appreciated. Delivered effectively, such counsel can promote satisfaction with abortion decisions, early prenatal care when a pregnancy is continued, and positive goal setting after the child is born.

Unlike other recent reviews, which primarily address preventing teenage pregnancy, we discuss counseling adolescents once pregnancy has occurred.[2-6] Our specific objectives are to provide requisite background, offer guidelines for building rapport, and identify issues pertinent to subsequent decision making.

The Scope of the Problem

Pregnancy, abortion, childbearing, and single parenthood rates in the United States are the highest among industrialized countries.[7] Key reasons include ambivalence about contraception as well as media influences that support adolescent sexuality. Substance abuse, physical and sexual abuse, family dysfunction, anxiety, and depression also predispose an adolescent to pregnancy and determine its consequences.[3,8] For some teenagers, pregnancy and childbearing are experimentation and risk-taking behaviors, abetted by attaining reproductive capacity in advance of cognitive and emotional maturity.[4] Teens who grow up in poverty or experience discrimination as members of minority groups may not perceive viable opportunities for educational or occupational advancement. They may be unwilling to defer childbearing because they see motherhood as the only adult role open to them.[5] In sum, adolescent pregnancy reflects underlying and ongoing tensions in American society. As these tensions will persist for the foreseeable future, the need to counsel already-pregnant teenagers will remain.

The need for such counseling is also evident from adolescent pregnancy rates.[9-12] With more than a million teen pregnancies annually, 1 in 10 American teenagers will conceive each year. Of these pregnancies 85% are unplanned, resulting in 400,000 abortions a year. Another 100,000 miscarry, and 500,000 pregnancies are continued to term. Much of this childbearing occurs outside marriage and is associated with ongoing poverty. Childbearing rates are highest for African-American, inner-city teenagers, but are rising rapidly among other racial and ethnic groups.[10,13] These births are increasingly to younger teenagers (ages 14 to 16), the group most likely to suffer medical and social adversity.[4] These include second-trimester abortions, which are more costly and traumatic than first-trimester terminations, or carrying an unwanted pregnancy to term.[14] Childbearing teenagers face a 60% excess in maternal mortality compared to adults and are more likely to suffer toxemia, anemia, hemorrhage, cervical trauma, cephalopelvic disproportion, excessive weight gain, and premature labor.[11] These complications are not inherent in the biologic aspects of adolescence, however. They are due more to social and behavioral correlates of adolescence, such as inadequate prenatal care, poor nutrition, substance abuse, or emotional distress, than to physiologic immaturity unless a teen is younger than age 15.[3] Infants born to teenage mothers are at substantially increased risk for prematurity or low birth weight and, consequently, for mortality and neurodevelopmental mor-

From the Department of Family and Community Medicine, Eastern Virginia Medical School, Norfolk, Virginia (Dr Bluestein), and Highland Hall Hospital, Ashville, North Carolina (Ms Starling).

Reprint requests to Daniel Bluestein, MD, Department of Family and Community Medicine, Eastern Virginia Medical School, PO Box 1980, Norfolk, VA 23501.

bidities.[10] A maternal age of 16 or less doubles the likelihood of low birth weight and triples infant mortality in the first month of life.[6] The mortality for infants born to young African-American women in this age group is nearly double the national average of 7.6 per 1,000 live births.

Unrecognized obstetrical injuries can predispose these children to subsequent academic or behavioral difficulties, along with inadequate parenting, unstable social environments, and socioeconomic disadvantage, in some instances.[15] Childbearing in adolescence can also prevent or delay educational and occupational advancement for many women.[8]

Communication Strategies

Many of the results of adolescent pregnancy can be improved with early pregnancy diagnosis and timely abortion or prenatal care. Pregnant adolescents delay health care, however, in part because services may be unavailable, inaccessible, unaffordable, or not geared to their needs.[16] Delay can also result from teenagers' unfamiliarity with pregnancy symptoms, not realizing the importance of early care, and emotional reactions such as denial, embarrassment, guilt, and fear.[17,18]

Teenagers are more likely to seek prompt follow-up and accept other health-promoting suggestions if they trust the source of this advice.[19] Building trust requires effective communication, the first prerequisite of which is guaranteed confidentiality.[20] Specifically, a teenager needs to know that her physician will not disclose the pregnancy without permission. This stance is congruent with the policies of the American Medical Association, of specialty organizations such as the American Academy of Family Physicians, and the "emancipated" legal status of pregnant minors in most states. Some adolescents may not be aware of their confidentiality rights and need information in this regard.

Patience is a second communication prerequisite, as repeated explanations and suggestions may be needed, depending on levels of anxiety and immaturity. Communication must be geared to emotional and intellectual development.[3] Adolescents aged 11 to 14 may have difficulty associating present actions with future consequences and need explicit guidance in the realities of pregnancy and parenthood. Adolescents aged 14 to 17 are preoccupied with asserting independence, and their rebelliousness can elicit defensiveness against health care professionals, which is to be avoided.[21] Because adolescents are concerned with peer approval, scenarios involving a "hypothetical friend"—If you had a friend who was pregnant, what would you tell her?—may be a useful strategy. Older teenagers aged 17 to 19 use more adult reasoning and can be treated as adults, but they can revert to immature thinking during the crisis of an unplanned pregnancy.[21,22]

Open communication is also more likely if a physician is perceived as nonjudgmental. Authoritarianism and imposing of personal views on issues such as abortion or unwed parenthood are counterproductive. A physician must be willing to recognize that adolescent sexuality and pregnancy are not inherently deviant behaviors and that teenage childbearing is not necessarily negative. Adverse medical and psychosocial consequences are distressingly frequent, but are not inevitable or even typical.[12] A longitudinal study of Baltimore teenagers points to a diversity of outcomes, with many teenage mothers—mostly black, inner-city residents—able to complete high school, find employment, and move off welfare, and many of their offspring making substantial progress toward independent adulthood.[23] A supportive social network, including but not limited to parents, male partners, and blood relatives, the adolescent's own capacity for interpersonal ties, her previous educational achievement, and having high future aspirations all predict successful teenage childbearing regardless of socioeconomic circumstances.[15]

There is, however, much heterogeneity, both within and between sociodemographic groups, in familial and cultural attitudes regarding teenage pregnancy and parenthood. A physician must therefore explore a teen's family and social environment without stereotypic preconceptions. Such an appraisal is key to assessing risks and to establishing dialogue around the emotionally laden and often threatening issue of family involvement. Family and social support promotes earlier care and improved clinical results for both abortion and childbearing and should be encouraged whenever possible.[17,24] On the other hand, disclosure may lead to rejection or abuse by a teen's family of origin. Problems are compounded if the adolescent pregnancy is symptomatic of family dysfunction.[25,26] In families that repress personal growth, a teenager's pregnancy may be her means of asserting independence. In others, the teen pregnancy may have diverted attention from more distressing conflicts and may have been tacitly encouraged. Familial substance abuse and violence, including possible sexual abuse, are also more likely to be present.[27] These issues may necessitate a referral to mental health care, perhaps urgently if there is concern about the patient's physical safety in disclosing the pregnancy. Nonthreatening and open-ended questions such as these, based on Smilkstein's Family APGAR, may help initiate discussions:[28]

- Do you enjoy being with your family?
- Can you turn to your family when something is bothering you?
- Can you talk to your family?
- Does your family get upset when you try something new?
- Does your family get upset if you express strong feelings?

When a Teenager Considers Abortion

A newly pregnant teenager must decide whether to continue the pregnancy. Such decisions are difficult regardless of age, but for teenagers, lack of information poses additional difficulties.[29] Some teenagers need clarification regarding the legality, availability, and timing of abortion. Although concerns about safety will remain, the medical risks of first-trimester terminations for teenagers are generally low.[30] Fever, hemorrhage, and emergency

abdominal surgical procedures occur in 1 to 2 per 1,000 teenagers undergoing first-trimester abortions. These rates are slightly lower than those for older women, and the teen mortality rate of 1.3 per 100,000 procedures is approximately half that of adults. The rate for cervical injury, which could affect subsequent childbearing, is 5.5 per 1,000 procedures among teenagers, notably higher than the rate for adults of 1.7 to 3.1 per 1,000. Fears about abortion-related emotional trauma are generally unfounded.[29]

All other options—parenthood or adoption—should be examined to ensure a complete appraisal.[8] The effect of a teenager's decision on her education or job plans should be discussed so that her choice supports her long-term goals. The risk of unsupported single parenthood or a premature, often unsuccessful, marriage should be explored as well. Most research indicates that teenagers older than age 15 have sufficient maturity for these assessments.[26,31] The advice of family and physician are important, but the decision should not be externally imposed. Careful consideration and ownership of the decision can offer a sense of personal control that promotes successful adjustment and encourages responsible sexual behavior.

Childbearing and Beyond

Childbearing teenagers need prenatal care, which can avert much of the risk associated with adolescent pregnancy.[4] Nonetheless, half of teenagers start prenatal care in the second trimester, 10% in the third trimester, and 2.4% receive no prenatal care.[32] For teenagers, the most salient reasons for this delay include denial, persisting family concerns, fear of labor and delivery, financial barriers, not knowing where or how to get prenatal care, and not appreciating its importance.[17] Black teenagers are more likely to delay seeking care than other racial and ethnic groups, a tendency that is not fully explained by differences in access to care.[33] Studies among nonobstetric groups of adolescents and among adults point to racial and ethnic differences in health-related attitudes and beliefs, which, among African Americans, may include untapped dissatisfaction with previous health care, a lower perception of the efficacy of health care or the seriousness of a given condition, and a tendency to seek help from family first.[34-36] Physicians should be aware of racial and ethnic differences in the use of health care and adjust counseling strategies as understanding of these differences increases.

Other counseling interventions include discussing a patient's fears about childbirth and addressing any misconceptions. When family insurance coverage is lacking, a physician may need to make suggestions as to where and how to apply for Medicaid or other available assistance. Providing information on which facilities serve teenagers who are pregnant and details on transportation, hours of operation, and how to obtain appointments can help increase teenagers' access to care.

Screening for gonorrhea, chlamydia, and bacterial vaginosis should be considered, especially if there is a long wait before a prenatal visit can be scheduled.[16] These infections may cause premature labor that earlier treatment can prevent. Perhaps most important, the value of prenatal care should be emphasized.[17]

Peer opinion is important in determining the attitude of teenagers. Discussing the experiences of friends is a means of assessing beliefs concerning prenatal care and identifying those teenagers unlikely to seek it in a timely fashion.[37] Follow-up telephone contact with some patients may encourage care that would otherwise be delayed or foregone.

A pregnant teenager's long-term plans should also be discussed. For some patients, information about adoption may be appropriate. Those teenagers who will keep their infants—95%—must answer a number of complex questions:

- Where will you live?
- Will you stay in school?
- Who will help you take care of your baby?
- Will the baby's father be involved? How about your parents or his family?
- Where will you and your baby get health care?
- How will you handle money?
- How soon do you plan to have another baby?

Visits for immunizations and infant health care may provide an opportunity for continuing these discussions after the baby is born.[4] Screening for maternal depression is important because expectations of parenthood may be dashed by the realities of caring for an infant.[4] The 20-item Center for Epidemiologic Studies depression scale is a valid screening tool for adolescents, with scores higher than 22 suggesting a clinically significant disorder and the need for further assessment.[38,39] Parenting programs can provide essential skills for teenaged mothers, and information on day-care services may enable them to continue their education. Contraceptive guidance is perhaps most important, however, as closely-spaced subsequent pregnancies strongly predict a truncated education, limited vocational skills, single parenthood, and long-term disadvantage.[2,9,11]

Conclusion

Teenage pregnancy and childbearing are embedded in our social fabric and will remain health care concerns. When pregnancy has already occurred, physicians can help teenagers reach sound decisions concerning pregnancy resolution and seek timely health care appropriate to those decisions. The communication methods outlined here can be adapted to the care of adolescents regardless of sex or gestational status and need not be limited to a reproductive context.

REFERENCES

1. Ringdahl EN: The role of the family physician in preventing teenage pregnancy. Am Fam Physician 1992; 45:2215-2220

2. McGrew MC, Shore WB: The problem of teenage pregnancy. J Fam Pract 1991; 32:17-21, 25

3. Alexander B, McGrew MC, Shore WB: Adolescent sexuality issues in office practice. Am Fam Physician 1991; 44:1273-1281

4. Stevens-Simon C, White M: Adolescent pregnancy. Pediatr Ann 1991; 20:322-331

5. Stevens-Simon C, White M: Recent developments in adolescent pregnancy. Curr Probl Pediatr 1992; 22:295-301

6. Rauh JL: The pediatrician's role in assisting teenagers to avoid the consequences of adolescent pregnancy. Pediatr Ann 1993; 22:90-91, 95-98

7. Hoekelman RA: Teenage pregnancy—One of our nation's most challenging dilemmas (Editorial). Pediatr Ann 1993; 22:81-82

8. Zakus G, Wilday S: Adolescent abortion option. Soc Work Health Care 1987; 12:77-91

9. Trussell J: Teenage pregnancy in the United States. Fam Plann Perspect 1988; 20:262-272

10. Furstenberg FF: Race differences in teenage sexuality, pregnancy, and adolescent childbearing. Milbank Q 1987; 44:383-403

11. Alexander CS, Guyer B: Adolescent pregnancy: Occurrence and consequences. Pediatr Ann 1993; 22:85-88

12. Testa MF: Introduction, *In* Rosenheim MK, Testa MF (Eds): Early Parenthood and Coming of Age in the 1990s. New Brunswick, NJ, Rutgers University Press, 1992, pp 1-16

13. Testa MF: Racial and ethnic variation in the early life course of adolescent welfare mothers, *In* Rosenheim MK, Testa MF (Eds): Early Parenthood and Coming of Age in the 1990s. New Brunswick, NJ, Rutgers University Press, 1992, pp 89-112

14. Hayes CD (Ed): Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing,Vol 1. Washington, DC, National Academy Press, 1987, p 114

15. Pope SK, Whiteside L, Brooks-Gunn J, et al: Low-birthweight infants born to adolescent mothers: Effects of coresidency with grandmother on child development. JAMA 1993; 269:1396-1400

16. Pomeranz AJ, Matson SC, Nelson DB: Delay in obstetrical care in newly diagnosed teenage pregnancy. Clin Pediatrics 1991; 30:661-663

17. Brown SS: Drawing women into prenatal care. Fam Plann Perspect 1989; 21:73-80

18. Bluestein DA, Rutledge CM: Determinants of delayed pregnancy testing among adolescents. J Fam Pract 1992; 35:406-410

19. Joos SK, Hickam DH: How health professionals influence health behavior: Patient-provider interaction and health care outcomes, *In* Glanz K, Lewis FM (Eds): Health Behavior and Health Education: Theory, Research, and Practice. San Francisco, Calif, Jossey-Bass, 1990

20. Council on Scientific Affairs, American Medical Association: Confidential health services for adolescents. JAMA 1993; 269:1420-1424

21. Strauss SS, Clarke BA: Decision-making patterns in adolescent mothers. Image: J Nursing Scholarship 1992; 24:69-74

22. Hughes CB, Torre C: Predicting effective contraceptive behavior in college females. Nurse Pract 1987; 12:44-51

23. Furstenberg FF, Hughes ME, Brooks-Gunn J: The next generation: The children of teenage mothers grow up, *In* Rosenheim MK, Testa MF (Eds): Early Parenthood and Coming of Age in the 1990s. New Brunswick, NJ, Rutgers University Press, 1992, pp 113-135

24. Council on Ethical and Judicial Affairs, American Medical Assocation: Mandatory parental consent to abortion. JAMA 1993; 269:82-86

25. Barnett WK, Papini DR, Gbur E: Familial correlates of sexually active pregnant and nonpregnant adolescents. Adolescence 1991; 26:457-472

26. Adler NE, David HP, Major BN, Roth SH, Russo NF, Wyatt GE: Psychological factors in abortion: A review. Am Psychologist 1992; 47:1194-1204

27. Boyer D, Fine D: Sexual abuse as a factor in adolescent pregnancy and child maltreatment. Fam Plann Perspect 1992; 24:4-11, 19

28. Smilkstein G: The Family APGAR: A proposal for a family function test and its use by physicians. J Fam Pract 1978; 6:1231-1239

29. Stone R, Waszak C: Adolescent knowledge and attitudes about abortion. Fam Plann Perspect 1992; 241:52-57

30. Cates W, Schulz KF, Grimes DA: The risks associated with teenage abortion. N Engl J Med 1983; 309:621-624

31. Zabin LS, Sedivy V: Abortion among adolescents: Research findings and the current debate. J Sch Health 1992; 62:319-24

32. Van Winter JT, Simmons PS: A proposal for obstetric and pediatric management of adolescent pregnancy. Mayo Clin Proc 1990; 65:1061-1066

33. Blankson ML, Cliver SP, Goldenberg RL, Hickey CA, Jin J, Dubard MB: Health behavior and outcomes in sequential pregnancies of black and white adolescents. JAMA 1993; 269:1401-1403

34. Lieu TA, Newacheck PW, McManus MA: Race, ethnicity, and access to ambulatory care among US adolescents. Am J Public Health 1993; 83:960-965

35. Strogatz DS: Use of medical care for chest pain: Differences between blacks and whites. Am J Public Health 1990; 80:290-294

36. Bailey EJ: Sociocultural factors and health-care seeking behavior among black Americans. J Natl Med Assoc 1987; 79:389-392

37. Morris DL, Berenson AB, Lawson J, Wiemann CM: Comparison of adolescent pregnancy outcomes by prenatal care source. J Reprod Med 1993; 38: 375-380

38. Reis J: The structure of depression in community-based young adolescent, older adolescent, and adult mothers. Fam Relations 1989; 38:164-168

39. Garrison CZ, Addy CL, Jackson KL, McKeown RE, Waller JL: The CES-D as a screen for depression and other psychiatric disorders in adolescents. J Am Acad Child Adolesc Psychiatry 1991; 30:636-641